Screening/Admission Progress Note

Required for OMH Programs only: IPRT, Mental Health Clinics, Partial Hospitalization Programs, ACT Teams, CDT, and PROS.

Data Field	Identifying Information Instruction
Organization Name	Enter your organization name.
Program Name	Enter your program name.
Individual's Name	Record the first name, middle initial and last name of the Individual served. Order of name is at agency discretion.
Record #	Record your agency's established record number for the Individual served.
DOB	Record the Individual's date of birth. **Example : mm/dd/yyyy**
Admission Date	Record the admission date using the month, day, and year. **Example: mm/dd/yyyy**.
Service Plan Due	Record the date the service plan is due. **Example : mm/dd/yyyy**
Referral source	Identify referral source, agency affiliation, name, address, title of contact and phone number.
Reason for referral	Describe reason for referral.
Diagnosis	Complete all diagnosis codes as applicable.
Narrative	Provide additional information if necessary.
Results of Psychiatric Rehabilitation Readiness Determination (IPRT Only)	Indicate the score as a result of completing the readiness determination. Include any referrals and pertinent information.
Admission indicated	Check box that applies. Indicate the reason for admission or reason for non-admission, disposition, and any referrals given.
Strengths	Describe the Individual's strengths.
Clinical, Immediate, and other services related to needs	Based on referral information and/or evaluation, describe the Individual's needs or issues to be addressed.
Rehabilitation aspirations (For IPRT only)	Describe what the Individual served wants to achieve from the rehabilitation experience? What is the person's desired outcome?
Initial services	List the services that will be delivered to meet the assessed needs. Specify the activities that staff will use to implement the services. Engagement, assessments, relapse prevention, crisis intervention etc.
Indicate collaterals interviewed if applicable	Indicate collaterals that were interviewed if applicable. (For OMH Mental Health Clinics, and Children's Day Treatment programs only)
Data Field	**Signature Instruction**
Print Staff Name/ Credentials/Title	Print staff name, credentials (degree/license) and title.
Staff Signature	Legible signature

Date	Record the date of signature, including the month, day and year. **Example : mm/dd/yyyy**
Supervisor Name/Credentials/Title (if needed)	Print the supervisor's name, credential (degree/license) and title of supervisor, if needed.
Supervisor Signature	Legible signature
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Individual's signature (optional)	Legible signature. This is encouraged, especially if the note was written collaboratively.
Date	Record the date of signature, including the month, day, and year. **Example : mm/dd/yyyy**
Medicare "Incident to" Services Only (if applicable)	Check the box when service is to be billed using the "incident to" billing rules.